

Item 28 Film 274 11-9-60									
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
12060									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART					d. STREET ADDRESS 35 ORCHARD STREET				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First HERBERT Middle P. Last AMBROSE					4. DATE OF DEATH Month 11 Day 1 Year 1960				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-9-94		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman		10b. KIND OF BUSINESS OR INDUSTRY B. and O. R.R.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOHN WESLEY AMBROSE (D)					14. MOTHER'S MAIDEN NAME MINNIE LEE AMBROSE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. PT'S CHART				
17. INFORMANT Address PT'S CHART									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease									
420-0 DUE TO (b) generalized arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) after amputation of right leg (mid thigh) on account of gangrene									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 3-2									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 3-2 19 59 to 11-1 19 60 , that (I) (we) last saw the deceased alive on 11-1 19 60 and that death occurred at 6:00 M., from the causes and on the date stated above.									
22a. SIGNATURE L. Brings M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) L. BRINGS 22d. ADDRESS 57 Greene Street, Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4 Nov 1960 23c. NAME OF CEMETERY OR CREMATORY Queens Point 23d. LOCATION (City, town, or county) (State) Keyser, W. Va.									
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Allen M. Refnick Keyser, W. Va. 25a. REC'D BY REGISTRAR DATE NOV 7 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

126110

CERTIFICATE OF DEATH

Common

S. and O. R. R.

Burial in Nov 1960 Queens Point

Keyser, W. Va.

Keyser,

W. Va.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12037

12061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 2 HRS. 40 MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. W. VA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANTOCH, W. VA d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDGAR Middle LEE Last BERG		4. DATE OF DEATH Month NOVEMBER Day 25 Year 19 60					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 25, 1888	9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) MAYSVILLE, W. VA			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDGAR L. BERG		14. MOTHER'S MAIDEN NAME FRANCES S. ROTRUCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH 12 HRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> NOV. 25, 1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 27 Nov 1960		22c. NAME OF CEMETERY OR CREMATORY Lahmansville			
22d. LOCATION (City, town, or county) (State) Lahmansville, W. Va.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Allen M. Rotruck</i> Keyser, W. Va.					
24a. REC'D BY REGISTRAR DATE NOV 28 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12061

NAME OF DECEASED BENJAMIN CHITTENDEN, JR.		SEX Male	
AGE 37		RACE White	
DATE OF DEATH Nov 27 1950		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 11:00 AM		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Physician		MARITAL STATUS Married	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF WITNESS [Signature]	
PRINTED NAME OF EXAMINER [Name]		PRINTED NAME OF WITNESS [Name]	
ADDRESS OF EXAMINER [Address]		ADDRESS OF WITNESS [Address]	
CITY AND STATE Baltimore, Md.		CITY AND STATE Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Florida b. COUNTY Hillsborough													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Petersburg											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 4315 10th St., North			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) NAOMI CATHERINE BIERCE				4. DATE OF DEATH Month November Day 15 , Year 1960													
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 6, 1919		9. AGE (In years last birthday) 41 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Oscar Strieby				14. MOTHER'S MAIDEN NAME Nellie Holzhauer				Fla.									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Miles W. Bierce				Address St. Petersburg, 4315 10th St., N.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO (b) Portal cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH 7-10 days --									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 11/15/60									
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11/18/60		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			22d. LOCATION (City, town, or county) (State) Cumberland, Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George					ADDRESS Cumberland, Md.			24a. REC'D BY REGISTRAR DATE NOV 21 '60									
					24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>												

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see-
 cure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

STATE OF ALABAMA DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS OFFICE OF THE REGISTRAR MONTGOMERY, ALA.

1. Name of deceased: JOHN W. BROWN
2. Sex: Male
3. Age: 45
4. Date of birth: 1910
5. Place of birth: Alabama
6. Race: White
7. Occupation: Farmer
8. Cause of death: Heart Disease
9. Date of death: 1955
10. Place of death: Home
11. Signature of Registrar: [Signature]
12. Date of registration: 1955

13. Name of physician: Dr. J. H. Smith
14. Signature of physician: [Signature]
15. Date of medical certificate: 1955

16. Name of informant: John W. Brown
17. Relationship to deceased: Self
18. Signature of informant: [Signature]
19. Date of information: 1955

20. Name of funeral home: None
21. Signature of funeral home: [Signature]
22. Date of funeral: 1955

23. Name of cemetery: None
24. Signature of cemetery: [Signature]
25. Date of burial: 1955

26. Name of coroner: None
27. Signature of coroner: [Signature]
28. Date of autopsy: 1955

29. Name of hospital: None
30. Signature of hospital: [Signature]
31. Date of admission: 1955

32. Name of doctor: None
33. Signature of doctor: [Signature]
34. Date of examination: 1955

35. Name of nurse: None
36. Signature of nurse: [Signature]
37. Date of admission: 1955

38. Name of pharmacist: None
39. Signature of pharmacist: [Signature]
40. Date of dispensing: 1955

41. Name of undertaker: None
42. Signature of undertaker: [Signature]
43. Date of preparation: 1955

44. Name of embalmer: None
45. Signature of embalmer: [Signature]
46. Date of embalming: 1955

47. Name of casket: None
48. Signature of casket: [Signature]
49. Date of purchase: 1955

50. Name of coffin: None
51. Signature of coffin: [Signature]
52. Date of purchase: 1955

53. Name of shroud: None
54. Signature of shroud: [Signature]
55. Date of purchase: 1955

56. Name of burial: None
57. Signature of burial: [Signature]
58. Date of burial: 1955

59. Name of interment: None
60. Signature of interment: [Signature]
61. Date of interment: 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12039

Reg. Dist. No.

12111

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u>			c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>528 Mill Street</u>				d. STREET ADDRESS <u>528 Mill Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>NMI</u> Last <u>BINGHAM</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>19 60</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1869</u>		9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Trainman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O RR</u>		11. BIRTHPLACE (State or foreign country) <u>Rainsburg, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Bingham</u>				14. MOTHER'S MAIDEN NAME <u>Susan Mowery</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Goldie B. Bingham</u> <u>528 Mill St., LaVale, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u> <u>54030</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Peptic Ulcer</u> (c) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1-2 Hrs.</u> ***-----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>November 28, 1960</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burila Park</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Cumberland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>C. J. Hafer</u>				24c. REGISTRAR'S SIGNATURE <u>C. J. Hafer</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12063

CERTIFICATE OF DEATH

12040

Item 9 Film 6276 12-2-60 et

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL NEAR BEDFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		d. STREET ADDRESS RT. 3, 75X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OTIS Middle W. Last BOOR		4. DATE OF DEATH Month 11 Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-31
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs & Gardner Bedford PENNA. Bedford Valley Pa.	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM BOOR		14. MOTHER'S MAIDEN NAME CLARA SIMMONS BOOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. I 72-26-7893	
17. INFORMANT PT'S CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Thermonia, streptococcal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and monilia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 12, 1960, to Nov. 26, 1960 that (I) (we) last saw the deceased alive on Mar 26, 1960 and that death occurred at 520p from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Ley Jr.		22b. DATE SIGNED 11/28/60	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY, M.D.		22d. ADDRESS 456 N. CENTER ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-60	
23c. NAME OF CEMETERY OR CREMATORY Fellowship Cem.		23d. LOCATION (City, town, or county) (State) Centerville, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR NOV 29 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1904

RECEIVED THE DEPARTMENT OF HEALTH
WASHINGTON, D. C. 20495

CERTIFICATE OF DEATH

12008

(M)

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAMES M. SMITH		45		M		W		JAN 15 1904		NEW YORK		HEART DISEASE	
RESIDENCE		BIRTH		MARRIAGE		OCCUPATION		EDUCATION		RELIGION		SIGNED	
123 MAIN ST. N.Y.		JAN 1 1859		MAY 1 1880		CLERK		HIGH SCHOOL		METHODIST		J. D. SMITH	
TESTED BY		DATE		SIGNED		SIGNED		SIGNED		SIGNED		SIGNED	
J. D. SMITH		JAN 16 1904		J. D. SMITH		J. D. SMITH		J. D. SMITH		J. D. SMITH		J. D. SMITH	

1

CHIEF CLERK

RECEIVED
JAN 16 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

12064

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12041

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYL AND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1 139 ELDER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARTIN Joseph BREIGHNER				4. DATE OF DEATH Month Day Year NOVEMBER 23 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1874		9. AGE (In years last birthday) yrs. 86	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Machinist		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) MT. UNION, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH M. BREIGHNER				14. MOTHER'S MAIDEN NAME Philomena SPAULDING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Coronary Artery Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 min						INTERVAL BETWEEN ONSET AND DEATH 15 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 20 1960 to Nov 23 1960 , that (I) (we) last saw the deceased alive on Nov 23 1960 , and that death occurred at 6:30 A M, from the causes and on the date stated above.							
22a. SIGNATURE DR. O. G. HIMMELWRIGHT				22b. DATE SIGNED 11/24/60		22c. PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT	
22d. ADDRESS 133 Va Ave, Cumberland, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/60		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 28 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. House			

15064

CERTIFICATE OF DEATH

15064

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WILLIAM

WILLIAM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12042

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural nr. Flintstone</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural, nr, Flintstone</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1, Flintstone</u>				d. STREET ADDRESS <u>Route 1, Flintstone</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>THURMAN</u> Last <u>BROWNING</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> , Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 10, 1889</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min.		IF UNDER 24 HRS. Hours <u>11</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corporation</u>		11. BIRTHPLACE (State or foreign country) <u>Rt. 1, Flintstone, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Meshach Browning</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Julia W. Browning, Indianapolis, Indiana</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MACERATION OF BRAIN</u> DUE TO <u>981X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GUNSHOT WOUND OF HEAD</u> DUE TO (c) <u>WOUND OF HEAD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>-----</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted gunshot wound</u>			
20c. TIME OF INJURY Month, Day, Year <u>Nov. 10 1960</u> Hour <u>9:00</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At home</u>		20f. (City or town) (County) (State) <u>Rt. 1, Flintstone, Maryland</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>November 10, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rt. 1, Flintstone, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12065

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12043

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 34 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 150 MT. PLEASANT ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle CARPENTER Last CARPENTER				4. DATE OF DEATH Month NOV. Day 3 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 16, 1914	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-MGR.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR CARPENTER				14. MOTHER'S MAIDEN NAME ROSE HAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-22-4443		17. INFORMANT PATIENTS CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 - 5 1960 , to 11 - 3 1960 , that (I) (we) last saw the deceased alive on 11 - 2 1960 , and that death occurred at 4:35 AM, from the causes and on the date stated above.							
22a. SIGNATURE Russ W. Ballin, M.D.				22b. DATE SIGNED 10-3-60		22c. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-5-60		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Burt				25a. REC'D BY REGISTRAR DATE NOV 7 '60		25b. REGISTRAR'S SIGNATURE Arthur E. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12062

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Blank form with horizontal lines for text entry.

12066

MD STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12044

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle Hanely Last CARTWRIGHT				4. DATE OF DEATH Month NOVEMBER Day 21 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 13, 1908	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Kopper Co.		11. BIRTHPLACE (State or foreign country) OLDTOWN, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LEVI CARTWRIGHT				14. MOTHER'S MAIDEN NAME LULA GROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-10-5621		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) Cardiac decompensation							INTERVAL BETWEEN ONSET AND DEATH 7 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 11/21 19 60 , that (I) (we) last saw the deceased alive on 11/21 19 60 , and that death occurred at 3:35 AM on the causes and on the date stated above.							
22a. SIGNATURE DR. GEORGE M. SIMONS				22b. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.		22c. PHYSICIAN'S (NAME) (Type) DR. GEORGE M. SIMONS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 1960		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a. REC'D BY REGISTRAR NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Turner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 12 hours after death.

18000

CERTIFICATE OF DEATH

ALLIANCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12067

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12045

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREAT CAPON	
d. STREET ADDRESS 85X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle R. Last CATLETT		4. DATE OF DEATH Month NOVEMBER Day 8 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 10, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BENJAMIN F. CATLETT		14. MOTHER'S MAIDEN NAME MARY JANE COROSEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia/Emphysema - Death 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia/Emphysema DUE TO (c) Bi lateral atelectasis cardio vascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheostomy 11-8-60.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 10-12-60 to 11-8-60 that (I) (we) last saw the deceased alive on 11-8-60 and that death occurred at 7:05 PM the causes and on the date stated above.			
22a. SIGNATURE W. F. Williams		22b. DATE 11-9-60	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 11/8/60		23b. DATE THEREOF 11/8/60	
23c. NAME OF CEMETERY OR CREMATORY WESLEY, CEM.		23d. LOCATION (City, town, or county) (State) GT. CAPON, MORGAN W. VA.	
24. FUNERAL DIRECTOR'S SIGNATURE James J. C. Lukely Spp. W. Va.		25. REC'D BY REGISTRAR DATE NOV 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

15043

AMERICAN DEPARTMENT OF HEALTH
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES OF AMERICA

15043

REPORT

WEST VIRGINIA

REPORT

REPORT

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12068

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12046

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN TB 3 DAYS			
d. NAME OF HOSPITAL (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARA Middle ELLEN Last CRITCHFIELD				4. DATE OF DEATH Month NOVEMBER Day 26 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 NOV. 16, 1882	
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress				10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JESSE CRITCHFIELD				14. MOTHER'S MAIDEN NAME REBECCA GESSNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Congestive Heart Failure acute Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic Aortic Aneurysm with myocardial and coronary insufficiency approx. 15 yrs (c) Acute Cerebrovascular Accident with Right Sided Paralysis and sensory deficit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 11/23/60							INTERVAL BETWEEN ONSET AND DEATH approx. 12 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/23 1960 , to 11/26 1960 , that (I) (we) last saw the deceased alive on 11/25 1960 , and that death occurred 7:22 AM from the causes and on the date stated above.							
22a. SIGNATURE John A. Topper				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/26/60	
22c. PHYSICIAN'S NAME (Type) JOHN A. TOPPER				22d. ADDRESS Hyndman Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 29, 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler, Hyndman, Pa				25a. REC'D BY REGISTRAR DATE NOV 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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CENTRAL CASE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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12069
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12047

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS WILEY FORD	
3. NAME OF DECEASED (Type or print) First FRANTIE Middle M. Last CROSS		4. DATE OF DEATH Month NOVEMBER Day 1 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1878
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY PAW PAW, W.VA.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL PRICE		14. MOTHER'S MAIDEN NAME MAGGIE MILES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease - Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 175			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11:30 P.M. 19 NOV 4 , that (I) (we) last saw the deceased alive on NOV 4 19 1960 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. R.J. WILLIAMS		22b. DATE SIGNED 11/7/60	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS		22d. ADDRESS Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/4/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc - Cumb. Md		25a. REC'D BY REGISTRAR DATE NOV 4 '60	
ADDRESS Louis Stein Inc - Cumb. Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

15002

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, say the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove notation papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clifford</u> First <u>Dean</u> Middle <u>Dean</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1886</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Murley's Branch, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Brooks Dean (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Swigert (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-5246</u>		17. INFORMANT <u>Patient's Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Cerebral Vascular Accident</u> <u>4-22-1</u> DUE TO <u>Arteriosclerotic cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio vascular disease</u> DUE TO (c) <u>Arteriosclerotic cardio vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11 - 8</u> <u>58</u> <u>11 - 19</u> <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11 - 8</u> <u>58</u> to <u>11 - 19</u> <u>60</u> , that (I) (we) last saw the deceased alive on <u>11 - 18</u> <u>1960</u> , and that death occurred at <u>7:35 A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph W. Balling</u>				22b. DATE SIGNED <u>11-19-60</u>		22c. PHYSICIAN'S NAME (Type) <u>Ralph W. Balling, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 21, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

1971



CERTIFICATE OF TITLE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12071

12049

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle T. Last DRESSMAN				4. DATE OF DEATH Month 11 Day 28 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-03	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store			
13. FATHER'S NAME JOSEPH DRESSMAN				14. MOTHER'S MAIDEN NAME MARY Detterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. —		17. INFORMANT PT'S CHART Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Superior Vena Caval Thrombophlebitis DUE TO (c) Reticular Cell Sarcoma INTERVAL BETWEEN ONSET AND DEATH unknown unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 22 Nov 1960 to 28 Nov 1960 , that (I) (we) last saw the deceased alive on 28 Nov 1960 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. Michael Glick				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK, MD				22d. ADDRESS 126 N. SMALLWOOD ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/1/60		23c. NAME OF CEMETERY OR CREMATORY St. Peter + Paul Cem		23d. LOCATION (City, town, or county) (State) Cumberland MD	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. MD		25a. REC'D BY REGISTRAR DEC 1 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

1901

1. Name of deceased *John Smith*
2. Age *45*
3. Sex *Male*
4. Date of death *Jan 15 1901*
5. Time of death *10:30 AM*
6. Place of death *Home*
7. Cause of death *Heart Disease*
8. Signature of physician *J. H. Jones*
9. Signature of registrar *W. B. Brown*
10. Signature of undertaker *C. D. Green*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12050

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #3 Cumberland				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 331 Route #3				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #3 Cumberland (Box 331)			
3. NAME OF DECEASED (Type or print) First Errett Middle Benton Last Harrison Elliott				4. DATE OF DEATH Month November Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 11, 1884	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee				10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Francis Elliott				14. MOTHER'S MAIDEN NAME Elken Sliger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-22-6625		17. INFORMANT Mrs. Millie A Elliott	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Colon with metastasis to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH ? 1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov 3 19 60 , to 20 Nov 19 60 , that (I) (we) last saw the deceased alive on 19 Nov 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Carlton Brunsfeld				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 21 1960	
22c. PHYSICIAN'S NAME (Type) CARLTON BRUNSFELD				22d. ADDRESS 232 Baltimore Ave Cumberland Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/60		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Bedford Rt #3 Penna	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR NOV 23 1960	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kray			

12150

CERTIFICATE OF DEATH

12151

12151

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
OFFICE: [illegible]

12151

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
OFFICE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
12072

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12051

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 3/3/58	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegany Barton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Fazenbaker Last Fazenbaker		4. DATE OF DEATH Month November Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1868
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 92 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Mark Fazenbaker	
14. MOTHER'S MAIDEN NAME Julia Ann Fazenbaker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.1 DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c) Acute Dehydration			INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/3/58 to 11/10/60 , that (I) (we) lost saw the deceased alive on 11/10/60 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE 11/11/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/13/60	23c. NAME OF CEMETERY OR CREMATORY Fazenbaker	23d. LOCATION (City, town, or county) (State) Barton, Allegany - Md
24. FUNERAL DIRECTOR'S SIGNATURE Es. Boat Western port, Md		25a. REC'D BY REGISTRAR DATE NOV 15 '60	25b. REGISTRAR'S SIGNATURE Charles E. Hughes

CERTIFICATE OF DEATH

13072

Alfred Nathan

Alfred Nathan

November 10, 1900

Alfred Nathan

Alfred Nathan

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Alfred Nathan

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12052

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle M. FAZENBAKER Last		4. DATE OF DEATH Month Nov Day 15 Year 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8th, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (State or foreign country) Garrett County		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Henry H. Fazenzbaker		16. MOTHER'S MAIDEN NAME Elizabeth Broadwater	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War #1		18. SOCIAL SECURITY NO.	
19. INFORMANT Mrs. Clarence Fazenzbaker, Lonaconig		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging by Rope around neck DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WOMcLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WOMcLane MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov, 19th, 1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery, Lonaconing, MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	
24a. REC'D BY REGISTRAR DATE NOV 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12053

12114

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>69 LaVale Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>E.</u> Last <u>GURLEY</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1914</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beard clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Company</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry J. Gurley</u>				14. MOTHER'S MAIDEN NAME <u>Leota R. Eyler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214 05 4148</u>		17. INFORMANT <u>Mrs. Mary Gurley, LaVale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Mild heart failure</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>9 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital? Heart Disease</u> (b) <u>40 yrs?</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-18-60</u> to <u>11-4-60</u> , that (I) (we) last saw the deceased alive on <u>11-4-60</u> , and that death occurred at <u>1A</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Lusby</u>				22b. DATE <u>Nov 7-60</u>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. LUSBY M.D.</u>	
22d. ADDRESS <u>125 BEDFORD ST. CUMBERLAND, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				25a. REC'D BY REGISTRAR <u>NOV 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

BP

18114

CERTIFICATE OF DEATH

MADE IN THE STATE OF NEW YORK
IN THE COUNTY OF ALBANY

1913

1

Under

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12073

12054

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 29 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIALS AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CANDACE WREATHA HATFIELD				4. DATE OF DEATH Month Day Year NOVEMBER 11, 1960.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 29, 1917	
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME STEPHEN KNIPPENBERG				14. MOTHER'S MAIDEN NAME LEONA IRONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix (Squamous) DUE TO (c) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 3 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on 6:50 AM from the causes and on the date stated above.							
22a. SIGNATURE DR. L. LEWIS MOULD				22b. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
22c. PHYSICIAN'S NAME (Type)				22d. DATE SIGNED 11/12/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 13, 1960		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.	
23d. LOCATION (City, town, or county) (State) Cumberland, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 14 '60		25b. REGISTRAR'S SIGNATURE Anthony L. House	

18051

CENTRAL ASIA OF RUSSIA

18051

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12074

12055

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 56 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVE				d. STREET ADDRESS 515 "B" STREET				
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK Lewis HAWKINS				4. DATE OF DEATH Month Day Year NOVEMBER 15 1960				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 20, 1893		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired salesman		10b. KIND OF BUSINESS OR INDUSTRY Swift Meat Co.		11. BIRTHPLACE (State or foreign country) BEDFORD, PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE HAWKINS				14. MOTHER'S MAIDEN NAME BLANCHE WELSH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-05-5886		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) yes							INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 30 1960 to November 15 1960 , that (I) (we) last saw the deceased alive on 11/15 1960 , and that death occurred at 3:10 A.M. from the causes and on the date stated above.								
22a. SIGNATURE George M. Simons				22b. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.		22c. DATE SIGNED 11/15/60		
22. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS				22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				25a. REC'D BY REGISTRAR NOV 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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RECEIVED AT THE ALBANY HOSPITAL, ALBANY, N.Y. 18001

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RECEIVED AT THE ALBANY HOSPITAL, ALBANY, N.Y. 18001

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RECEIVED AT THE ALBANY HOSPITAL, ALBANY, N.Y. 18001

12075

CERTIFICATE OF DEATH

12056

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland MD</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md 262</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>408 Walnut Street</u>		d. STREET ADDRESS <u>408 Walnut St. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>A</u> Last <u>Higgins</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Glenstone Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry A Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Fannie Higgins</u>		Address <u>Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 11, 1960</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 11, 1960</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. F. Johnson, Jr.</u>		DATE SIGNED <u>11-17-1960</u>	
PHYSICIAN'S NAME (Type) <u>J. F. Johnson, Jr.</u>		ADDRESS (Street, city or town, state) <u>16 Greene St, Cumberland Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>11/20/60</u>	22c. NAME OF CEMETERY OR CREMATOR <u>St. Patricks Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15093

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1925</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CITY OR TOWN <i>Baltimore</i>		8. COUNTY <i>Harford</i>		9. STATE <i>Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		14. SIGNATURE OF DECEASED <i>John J. Smith</i>		15. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
16. SIGNATURE OF REGISTRAR <i>J. H. Smith</i>		17. SIGNATURE OF CLERK <i>J. H. Smith</i>		18. SIGNATURE OF JURY <i>J. H. Smith</i>	
19. SIGNATURE OF JURY <i>J. H. Smith</i>		20. SIGNATURE OF JURY <i>J. H. Smith</i>		21. SIGNATURE OF JURY <i>J. H. Smith</i>	
22. SIGNATURE OF JURY <i>J. H. Smith</i>		23. SIGNATURE OF JURY <i>J. H. Smith</i>		24. SIGNATURE OF JURY <i>J. H. Smith</i>	
25. SIGNATURE OF JURY <i>J. H. Smith</i>		26. SIGNATURE OF JURY <i>J. H. Smith</i>		27. SIGNATURE OF JURY <i>J. H. Smith</i>	
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J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12076

12057

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 CUMBERLAND d. STREET ADDRESS Pleasant View Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS Patrick HIGHLAND		4. DATE OF DEATH Month Day Year NOVEMBER 3 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Station Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Pipe Line Co.	
11. BIRTHPLACE (State or foreign country) MARIETTA, OHIO		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN HIGHLAND		14. MOTHER'S MAIDEN NAME Briget Roland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 091-07-7700	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertensive 442X DUE TO Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Disease (b) Heart (c) Disease		INTERVAL BETWEEN ONSET AND DEATH Since Dec 57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-27-57 to 11-8-60 that (I) last saw the deceased alive on 11-8-1960 , and that death occurred at 4:45 PM on the causes and on the date stated above.			
22a. SIGNATURE W. F. Williams		22b. DATE SIGNED 11-9-60	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/60	
23c. NAME OF CEMETERY OR CREMATORY Newport Cemetery		23d. LOCATION (City, town, or county) (State) Newport, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR DATE NOV 14 60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1584

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
OFFICE OF VITAL RECORDS AND STATISTICS
STATE OF NEW YORK

ALBANY

ALBANY

ALBANY

DECEASED

3 DAYS

DECEASED

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110 STATE VIEW ROAD

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WOMEN

WOMEN

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[Faint, illegible text and signatures, likely bleed-through from the reverse side of the document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12058

12077

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4/14/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle May Last Hill		4. DATE OF DEATH Month November Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William M. Wadsworth		14. MOTHER'S MAIDEN NAME Mary Engle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO 722.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Rheumatoid Arthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/14/60 19 to 11/8/60 19, that (I) (we) last saw the deceased alive on 11/7/60 19, and that death occurred at 6:15 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean M.D.		22b. DATE SIGNED 11/8/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/10/60	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR DATE NOV 14 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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Dr. James L. Smith

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12059

12115

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence, Flintstone, Maryland</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERGMAN</u>		First <u>MILVEE</u> Middle <u>HINKLE</u> Last		4. DATE OF DEATH Nov. <u>13</u> 19 <u>60</u>		Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1874</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Murley's Branch, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sumerfield Hinkle</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Wolford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Agnes B. Hinkle, Flintstone, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-30-1960</u> to <u>11-13-1960</u> that (I) (we) last saw the deceased alive on <u>10-30-1960</u> and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. J. Johnson, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr. M.D.</u>				22d. ADDRESS <u>16 Greene Street, Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12078

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12060

1. PLACE OF DEATH a. COUNTY ALLEGANY b. STATE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 26 DAYS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 507 BEALL STREET					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First FLORENCE Middle L Last JOHNSON				4. DATE OF DEATH Month NOVEMBER Day 23 Year 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 22, 1892			
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68		IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. 68					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Ready Wear Shop					
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME WILLIAM E. JOHNSON				14. MOTHER'S MAIDEN NAME JOSEPHINE GRIFFLY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 319-14-6198					
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 3 HRS yes yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from May 1955 , to 11/23 , 19 60 , that (I) (we) last saw the deceased alive on 11/23 , 19 60 , and that death occurred at 7:45 AM from the causes and on the date stated above.									
22a. SIGNATURE George M. Simons				22b. DATE SIGNED NOV 28 1960					
22c. PHYSICIAN'S NAME (Type) GEORGE M. SIMONS				22d. ADDRESS 7245					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/26/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.			
23d. LOCATION (City, town, or county) (State) Cumberland MD									
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR DATE NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

STATE DEPARTMENT OF HEALTH
1918
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible] YEARS
SEX: [illegible]
RACE: [illegible]
BIRTH: [illegible]
DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
12079

12061

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. d. STREET ADDRESS 699 GEPHART DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First IVY Middle GLADYS Last JONES		4. DATE OF DEATH Month NOVEMBER Day 22 Year 19 60				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1898	9. AGE (In years last birthday) 62	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 2 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert TOOZE			14. MOTHER'S MAIDEN NAME ELEANOR ROGERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 216-22-5662		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 158 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, retroperitoneal, undifferentiated, DUE TO (c) site of origin undetermined. INTERVAL BETWEEN ONSET AND DEATH 8 hours 1 year						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11-14-		
20f. (City or town) 11-22-		20g. (County) 1960		20h. (State) 11-22-		
21. I certify that (I) (this hospital) attended the deceased from 11-14- to 11-22- 19 60 , that (I) (we) last saw the deceased alive on 11-22- 19 60 , and that death occurred at 6:25 P.M. from the causes and on the date stated above.						
22a. SIGNATURE DR. WYAND F. DOERNER, JR.		22b. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER, JR.		22c. DATE 11/25/60		
22d. ADDRESS WASHINGTON ST., CUMBERLAND, MD.		22e. DATE NOV 28 '60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/60		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		
23d. LOCATION (City, town, or county) Cumberland, Maryland		23e. (State) Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. ADDRESS Cumberland, Md.		24b. REC'D BY REGISTRAR NOV 28 '60		
24c. REGISTRAR'S SIGNATURE Arthur L. Jones		24d. DATE NOV 28 '60				

CERTIFICATE OF DEATH

12073

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

NAME OF REGISTRAR: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12080

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS ROUTE # 1 BOX 377	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HAROLD Middle R. Last KALLMYER		4. DATE OF DEATH Month NOVEMBER Day 19 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 16, 1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 15 Min. 00	IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY Consolidated Fuel	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME LEWIS KALLMYER		14. MOTHER'S MAIDEN NAME ELLEN WHETZEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 214-01-3768	17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) CORONARY SCLEROSIS (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DR. BENEDICT SKITARELIC		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-60	22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery
22d. LOCATION (City, town, or county) Eckhart, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. N. Burch		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE NOV 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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JAN 1976 - JAN 1977

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212 JULIO YRABO, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

121116

Item 6 Film 275 11-21-60 et

12063

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep		c. LENGTH OF STAY IN 1b 34 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION State Road		d. STREET ADDRESS State Road	
3. NAME OF DECEASED (Type or print) John Edmund Kight		4. DATE OF DEATH Nov. 15 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1883
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Kight		14. MOTHER'S MAIDEN NAME Eliza Gilbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-6164	
17. INFORMANT Mrs. John E. Kight-Nikep, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial strain DUE TO 241X Anteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchial asthma DUE TO years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Influenza INTERVAL BETWEEN ONSET AND DEATH hours years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 9 1956 to Nov 15 1960 that (I) (we) last saw the deceased alive on Oct 20 1960 , and that death occurred at 5am , from the causes and on the date stated above.			
22a. SIGNATURE Samuel Ford		22b. DATE SIGNED 11-15-60	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS Sonaeoning Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/60	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E.S. Bural		25a. REC'D BY REGISTRAR NOV 17 '60	
25b. REGISTRAR'S SIGNATURE Richard S. Fennell			

0151

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

24

Journal of Management Education 36(7) 809-824

62

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

12081 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>P.O. Box 15</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Emory Kimble</u>				4. DATE OF DEATH Month Day Year <u>November 29 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1933</u>		9. AGE (In years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>George Const. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Landis, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNXXX USA</u>	
13. FATHER'S NAME <u>Okey Kimble</u>				14. MOTHER'S MAIDEN NAME <u>Beaulah Alt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-38-5765</u>		17. INFORMANT <u>s. Charles E. Kimble</u> Address <u>P.O. BOX 15 Oldtown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 884.9 Conditions, if any, which gave rise to immediate cause (b) <u>Mercury Poisoning</u> (c) <u>Pending</u> DUE TO 7-8 Days INTERVAL BETWEEN ONSET AND DEATH 3-4 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitaralic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitaralic M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>November 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>	
						22d. LOCATION (City, lawn, or county) (State) <u>Allegany County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Huns</u>	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12064

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				d. STREET ADDRESS 214 FAYETTE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MARIE Last LAWLER				4. DATE OF DEATH Month 11 Day 28 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-92	
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Laing				14. MOTHER'S MAIDEN NAME Catherine Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Albert Lawler--214 Fayette St. Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident, prob. thrombosis, right hemisphere 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive and Arteriosclerotic Cardiovascular disease with cerebral arteriosclerosis and several old small strokes. DUE TO (c) several old small strokes.						INTERVAL BETWEEN ONSET AND DEATH 4 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 22 1960 to November 28, 19 60 that (I) (we) last saw the deceased alive on Novemb. 28, 19 60 , and that death occurred at 3:11 P , from the causes and on the date stated above.							
22a. SIGNATURE <i>Edward P. Doerner, M.D.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-30-60	
22c. PHYSICIAN'S NAME (Type) W.F. DOERNER, M.D.				22d. ADDRESS ALGONQUIN BUILDING, CITY			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1960		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a. REC'D BY REGISTRAR DEC 2 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

REPUBLIC OF DE GRAY

15000

UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

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OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12117

12065

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, near Cumberland</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1, Valley Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIET BEATRICE LILLER</u>		4. DATE OF DEATH Month Day Year <u>November 25 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1895</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McDowell, Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Botkin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-30-1562</u>	
17. INFORMANT <u>John Liller, Rt. 1, Valley Road,</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.9 Hemiparesis</u> DUE TO (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Bronchial Asthma, Carcinomatous??</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>6 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1958</u> to <u>Nov 1960</u> that (I) (we) last saw the deceased alive on <u>11-22-1960</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. James</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William P. James, M.D.</u>		22d. ADDRESS <u>441 Center St., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

18113

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
WASHINGTON, D. C.

18113

Form with multiple lines for text entry, including fields for name, date, and other vital statistics data. The text is faint and mostly illegible due to the quality of the scan.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
12083
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12066

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/26/58	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 68 Narrows Park, Nat. Hwy.	
3. NAME OF DECEASED (Type or print) First Edward Middle J. Last Logsdon		4. DATE OF DEATH Month November Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1880
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; R. R. Machinist		10b. KIND OF BUSINESS OR INDUSTRY (R. Road)	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry T. Logsdon		14. MOTHER'S MAIDEN NAME Sarah Smysing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Hepatitis, chronic, severe DUE TO (b) extensive ulceration, severe DUE TO (c) atalectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/26/58 to 11/19/60 , 19____, that (I) (we) last saw the deceased alive on 11/19/60 19____, and that death occurred at 7:35 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE 11/21/60	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE/THEREOF 11/23/60	
23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cn		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE James L. Smith Inc. Cumb. Md		25a. REC'D BY REGISTRAR DATE NOV 22 '60	
ADDRESS Cumb. Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

12064

12063

Allegany County, Maryland

Allegany County, Maryland

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Allegany County, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12084

CERTIFICATE OF DEATH

12067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1040 Bedford St.,		d. STREET ADDRESS 1040 Bedford St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fredericka Middle Mary Last Loibel		4. DATE OF DEATH Month Nov. Day 5, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1893
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Cutter		14. MOTHER'S MAIDEN NAME Jean Bobe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John J. Loibel		Address Cumberland, Md. 1040 Bedford St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema x Fibrosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/15 , 19 57 , to 11/5 , 19 60 , that I last saw the deceased alive on 9/21 , 19 60 , and that death occurred at 6:00 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.		ADDRESS (Street, city or town, state) 456 441 N. Centre St.,	
DATE SIGNED 11/7/60			
PHYSICIAN'S NAME (Type) William P. James M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/8/60	22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

12105

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6277 12-21-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12068

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG-MD</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LONA CONING MD</u>	
		d. STREET ADDRESS <u>11X-2</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>M</u> Last <u>McKenzie</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14, 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>11</u> Hours <u>20</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME - GARRETT CO MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH ROBESON</u>		14. MOTHER'S MAIDEN NAME <u>RHODA GARLITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-346524</u>	
17. INFORMANT <u>Raymond McKenzie, RD Lonaconing MD</u>		Address <u>RD Lonaconing MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion possible</u> DUE TO (c) <u>Cholecystectomy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>24 hrs.</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 11, 1960</u> , to <u>Nov 20, 1960</u> , that I last saw the deceased alive on <u>Nov 20, 1960</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>2 Broadway</u> DATE SIGNED <u>11/21/60</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, MD.</u>		<u>Frostburg, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST ANNE'S</u>		22d. LOCATION (City, town, or county) (State) <u>ALVITON, GARRETT CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman, Frostburg, MD</u>		ADDRESS <u>Frostburg, MD</u>	
24a. REC'D BY REGISTRAR <u>NOV 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Colman S. Thomas</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. HARRIS		SEX Male	
AGE 23		DATE OF BIRTH 1915	
PLACE OF BIRTH West Virginia		OCCUPATION Student	
MARITAL STATUS Single		CAUSE OF DEATH Pneumonia	
DATE OF DEATH 1938		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 AM		SIGNATURE OF PHYSICIAN J. H. Smith	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF WITNESS J. H. Smith	
SIGNATURE OF NEXT OF KIN (Blank)		SIGNATURE OF BURIAL OFFICIAL (Blank)	
SIGNATURE OF REGISTRAR (Blank)		SIGNATURE OF CLERK (Blank)	

RECEIVED
 BALTIMORE
 JAN 20 1938
 DEPT. OF HEALTH

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Md., and a copy of the same is to be sent to the office of the Registrar of the Department of Health, West Virginia, Charleston, W. Va.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12089 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>158 1/2 Bedford Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>158 1/2 Bedford Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MYRTLE JENNIE MERRILL</u>				4. DATE OF DEATH Month Day Year <u>November 25 19 60</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 17, 1886</u>							
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mann's Choice, Pennsylvania</u>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>David Keifer</u>							
14. MOTHER'S MAIDEN NAME <u>Dilla Malissa Barthalow</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)							
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mrs. Ray Frankenberry, Cresaptown, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> </td> <td rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </td> </tr> <tr> <td rowspan="2"> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> DUE TO (b) <u>Coronary Sclerosis</u> </td> </tr> <tr> <td> DUE TO (c) _____ </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Sclerosis</u>	DUE TO (c) _____
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Sclerosis</u>										
	DUE TO (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>November 25, 1960</u>				DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Savage Meth. Cemetery</u>							
22d. LOCATION (City, town, or county) <u>Mt. Savage, Maryland</u>		22e. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1917

LOCAL RECORDS SECTION		MAY 1917	
NAME OF DECEASED		SEX	
AGE		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		LABORATORY EXAMINATIONS	
POST-MORTEM EXAMINATION		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		OFFICE OF THE EXAMINER	

RECEIVED
MAY 1917
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

12086										12070									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN lb 114 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR MEMORIAL HOSPITAL OR MEMORIAL & WARWICK AVE.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND d. STREET ADDRESS 1118 OAK ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last MILLER					4. DATE OF DEATH Month NOVEMBER Day 26 Year 1960														
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 7, 1889		9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman					10b. KIND OF BUSINESS OR INDUSTRY Railroad					11. BIRTHPLACE (State or foreign country) MANN'S CHOICE, PENNA.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME EMMANUEL MILLER					14. MOTHER'S MAIDEN NAME ARMANDA FLEEGLER														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 705-07-9529					17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.01 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis (c) 8 yrs										INTERVAL BETWEEN ONSET AND DEATH 6 mths									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from June 1957 to Nov. 26, 1960 , that (I) (we) last saw the deceased alive on Nov. 26, 1960 , and that death occurred at 8:15 P.M. the causes and on the date stated above.																			
22a. SIGNATURE Clay E. Durrett					22b. DATE SIGNED														
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT					22d. ADDRESS 236 W. 1st St. Cumberland, Md. 1/28/60														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-30-60					23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.					23d. LOCATION (City, town, or county) (State) Cumberland, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli					ADDRESS Cumberland, Md.					25a. REC'D BY REGISTRAR NOV 29 '60					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

12000

CERTIFICATE OF DEATH

ALLICANT

DECEASED

DECEASED

DECEASED

DECEASED

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DECEASED

DR. CLAY E. DUNN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12087

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12071

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHERINE Middle Lupton Last NAVE				4. DATE OF DEATH Month NOVEMBER Day 2 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 14, 1914	
9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Employee				10b. KIND OF BUSINESS OR INDUSTRY Memorial Hospital			
13. FATHER'S NAME FRED SMITH				14. MOTHER'S MAIDEN NAME CATHERINE SHAFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple emboli 420.1 DUE TO Mural thrombi Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular fibrillation, acute post-mitral (c) coronary artery PART II. OTHER SIGNIFICANT CONDITIONS CONTINUING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multi-valvular rheumatic disease; hypertension INTERVAL BETWEEN ONSET AND DEATH immediate							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/25 19 60 to 11/2 19 60 , that (I) (we) last saw the deceased alive on 11/2 19 60 , and that death occurred 1:15 AM on 11/3/60 at Memorial Hospital because of and on the date stated above.							
22a. SIGNATURE Samuel M. Jacobson				22b. DATE SIGNED 11/3/60			
22c. PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M. D.				22d. ADDRESS 50 Pershing St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town, or county) (State) Cumberland, Maryland				23e. REC'D BY REGISTRAR Nov 7 '60			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13007

CERTIFICATE OF DEATH

MILITARY

MARRIAGE

ALLIANCE

DATE

CLASS

RECEIVED

NOTICE

FORM

DATE

FATHER'S NAME

DEED

GENERAL HOSPITAL, CHICAGO, ILL.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DEATH CERTIFICATE

DATE

TIME

X

DEATH CERTIFICATE

DATE

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12072

12106

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 73 Bowery Street				d. STREET ADDRESS 73 Bowery Street			
3. NAME OF DECEASED (Type or print) WILLIAM First ALBERT Middle PATTON Last				4. DATE OF DEATH Month 11 Day 27 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-1911		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Dye Assembly		10b. KIND OF BUSINESS OR INDUSTRY Cleveland, Ohio Republic Steel		11. BIRTHPLACE (State or foreign country) Eckhart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Patton				14. MOTHER'S MAIDEN NAME Marie Brunner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-5267		17. INFORMANT Mrs. Olive Patton, 73 Bowery, Frostburg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) a CORONARY OCCLUSION, RIGHT DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis with thrombosis DUE TO (c) ----							INTERVAL BETWEEN ONSET AND DEATH 2-4 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W O McLane M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W.O. McLane, Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER W O McLane				DATE SIGNED November 27, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-30-1960		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesant ADDRESS 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR DEC 1 '60		24b. REGISTRAR'S SIGNATURE Robert S. Hanes	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18092

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12108

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH 11-11-1918		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Pneumonia	
9. DISEASE OR INJURY Pneumonia		10. MANNER OF DEATH Natural	
11. SIGNATURE OF EXAMINER J. H. HARRIS		12. SIGNATURE OF WITNESSES J. H. HARRIS	
13. SIGNATURE OF DECEASED J. H. HARRIS		14. SIGNATURE OF NEXT OF KIN J. H. HARRIS	
15. SIGNATURE OF BURIAL OFFICER J. H. HARRIS		16. SIGNATURE OF MINISTER OF THE GOSPEL J. H. HARRIS	
17. SIGNATURE OF CLERGYMAN J. H. HARRIS		18. SIGNATURE OF CHURCH J. H. HARRIS	
19. SIGNATURE OF FUNERAL HOME J. H. HARRIS		20. SIGNATURE OF CEMETERY J. H. HARRIS	
21. SIGNATURE OF INTERVIEWER J. H. HARRIS		22. SIGNATURE OF REPORTER J. H. HARRIS	
23. SIGNATURE OF CLERK J. H. HARRIS		24. SIGNATURE OF ASSISTANT CLERK J. H. HARRIS	
25. SIGNATURE OF RECEPTIONIST J. H. HARRIS		26. SIGNATURE OF TELEPHONE OPERATOR J. H. HARRIS	
27. SIGNATURE OF MAIL ROOM J. H. HARRIS		28. SIGNATURE OF RECORDS SECTION J. H. HARRIS	
29. SIGNATURE OF IDENTIFICATION SECTION J. H. HARRIS		30. SIGNATURE OF LABORATORY SECTION J. H. HARRIS	
31. SIGNATURE OF RADIOLOGY SECTION J. H. HARRIS		32. SIGNATURE OF PATHOLOGY SECTION J. H. HARRIS	
33. SIGNATURE OF BACTERIOLOGY SECTION J. H. HARRIS		34. SIGNATURE OF CHEMISTRY SECTION J. H. HARRIS	
35. SIGNATURE OF PHYSIOLOGY SECTION J. H. HARRIS		36. SIGNATURE OF ANATOMY SECTION J. H. HARRIS	
37. SIGNATURE OF HISTOLOGY SECTION J. H. HARRIS		38. SIGNATURE OF MICROBIOLOGY SECTION J. H. HARRIS	
39. SIGNATURE OF PHARMACOLOGY SECTION J. H. HARRIS		40. SIGNATURE OF TOXICOLOGY SECTION J. H. HARRIS	
41. SIGNATURE OF FORENSIC SECTION J. H. HARRIS		42. SIGNATURE OF MEDICAL SECTION J. H. HARRIS	
43. SIGNATURE OF DENTAL SECTION J. H. HARRIS		44. SIGNATURE OF OPTIC SECTION J. H. HARRIS	
45. SIGNATURE OF PODIATRY SECTION J. H. HARRIS		46. SIGNATURE OF VETERINARY SECTION J. H. HARRIS	
47. SIGNATURE OF NURSING SECTION J. H. HARRIS		48. SIGNATURE OF PHARMACY SECTION J. H. HARRIS	
49. SIGNATURE OF MEDICAL ASSISTANT SECTION J. H. HARRIS		50. SIGNATURE OF LABORATORY ASSISTANT SECTION J. H. HARRIS	
51. SIGNATURE OF RADIOLOGY ASSISTANT SECTION J. H. HARRIS		52. SIGNATURE OF PATHOLOGY ASSISTANT SECTION J. H. HARRIS	
53. SIGNATURE OF BACTERIOLOGY ASSISTANT SECTION J. H. HARRIS		54. SIGNATURE OF CHEMISTRY ASSISTANT SECTION J. H. HARRIS	
55. SIGNATURE OF PHYSIOLOGY ASSISTANT SECTION J. H. HARRIS		56. SIGNATURE OF ANATOMY ASSISTANT SECTION J. H. HARRIS	
57. SIGNATURE OF HISTOLOGY ASSISTANT SECTION J. H. HARRIS		58. SIGNATURE OF MICROBIOLOGY ASSISTANT SECTION J. H. HARRIS	
59. SIGNATURE OF PHARMACOLOGY ASSISTANT SECTION J. H. HARRIS		60. SIGNATURE OF TOXICOLOGY ASSISTANT SECTION J. H. HARRIS	
61. SIGNATURE OF FORENSIC ASSISTANT SECTION J. H. HARRIS		62. SIGNATURE OF MEDICAL ASSISTANT SECTION J. H. HARRIS	
63. SIGNATURE OF DENTAL ASSISTANT SECTION J. H. HARRIS		64. SIGNATURE OF OPTIC ASSISTANT SECTION J. H. HARRIS	
65. SIGNATURE OF PODIATRY ASSISTANT SECTION J. H. HARRIS		66. SIGNATURE OF VETERINARY ASSISTANT SECTION J. H. HARRIS	
67. SIGNATURE OF NURSING ASSISTANT SECTION J. H. HARRIS		68. SIGNATURE OF PHARMACY ASSISTANT SECTION J. H. HARRIS	
69. SIGNATURE OF MEDICAL ASSISTANT SECTION J. H. HARRIS		70. SIGNATURE OF LABORATORY ASSISTANT SECTION J. H. HARRIS	
71. SIGNATURE OF RADIOLOGY ASSISTANT SECTION J. H. HARRIS		72. SIGNATURE OF PATHOLOGY ASSISTANT SECTION J. H. HARRIS	
73. SIGNATURE OF BACTERIOLOGY ASSISTANT SECTION J. H. HARRIS		74. SIGNATURE OF CHEMISTRY ASSISTANT SECTION J. H. HARRIS	
75. SIGNATURE OF PHYSIOLOGY ASSISTANT SECTION J. H. HARRIS		76. SIGNATURE OF ANATOMY ASSISTANT SECTION J. H. HARRIS	
77. SIGNATURE OF HISTOLOGY ASSISTANT SECTION J. H. HARRIS		78. SIGNATURE OF MICROBIOLOGY ASSISTANT SECTION J. H. HARRIS	
79. SIGNATURE OF PHARMACOLOGY ASSISTANT SECTION J. H. HARRIS		80. SIGNATURE OF TOXICOLOGY ASSISTANT SECTION J. H. HARRIS	
81. SIGNATURE OF FORENSIC ASSISTANT SECTION J. H. HARRIS		82. SIGNATURE OF MEDICAL ASSISTANT SECTION J. H. HARRIS	
83. SIGNATURE OF DENTAL ASSISTANT SECTION J. H. HARRIS		84. SIGNATURE OF OPTIC ASSISTANT SECTION J. H. HARRIS	
85. SIGNATURE OF PODIATRY ASSISTANT SECTION J. H. HARRIS		86. SIGNATURE OF VETERINARY ASSISTANT SECTION J. H. HARRIS	
87. SIGNATURE OF NURSING ASSISTANT SECTION J. H. HARRIS		88. SIGNATURE OF PHARMACY ASSISTANT SECTION J. H. HARRIS	
89. SIGNATURE OF MEDICAL ASSISTANT SECTION J. H. HARRIS		90. SIGNATURE OF LABORATORY ASSISTANT SECTION J. H. HARRIS	
91. SIGNATURE OF RADIOLOGY ASSISTANT SECTION J. H. HARRIS		92. SIGNATURE OF PATHOLOGY ASSISTANT SECTION J. H. HARRIS	
93. SIGNATURE OF BACTERIOLOGY ASSISTANT SECTION J. H. HARRIS		94. SIGNATURE OF CHEMISTRY ASSISTANT SECTION J. H. HARRIS	
95. SIGNATURE OF PHYSIOLOGY ASSISTANT SECTION J. H. HARRIS		96. SIGNATURE OF ANATOMY ASSISTANT SECTION J. H. HARRIS	
97. SIGNATURE OF HISTOLOGY ASSISTANT SECTION J. H. HARRIS		98. SIGNATURE OF MICROBIOLOGY ASSISTANT SECTION J. H. HARRIS	
99. SIGNATURE OF PHARMACOLOGY ASSISTANT SECTION J. H. HARRIS		100. SIGNATURE OF TOXICOLOGY ASSISTANT SECTION J. H. HARRIS	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12073

12088

1. PLACE OF DEATH a. COUNTY ALLGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 6 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 12 CENTRAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle ESTELLA Last PHILLIPS				4. DATE OF DEATH Month NOVEMBER Day 3 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1905		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 55 Days 55	IF UNDER 24 HRS. Hours 55 Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinning employee		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EMORY BROWN (DECEASED)				14. MOTHER'S MAIDEN NAME SARAH TRADER (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. No,		17. INFORMANT Address Ridgeley, W.Va. Mr. Leslie C. Phillips 12 Central Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Maceration of Brain DUE TO 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of head DUE TO (c) 6 Hrs. 6 Hrs.							INTERVAL BETWEEN ONSET AND DEATH 6 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head (suicide)					
20c. TIME OF INJURY Month, Day, Year Hour 6:45 Nov. 3 1960 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Ridgeley, Mineral, W.Va. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		NOVEMBER # 3, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/60		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		22d. LOCATION (City, lawn, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 7 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

1

12089

CERTIFICATE OF DEATH

12074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>50yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Race St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sylvester</u> First <u>Pittman</u> Middle Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1895</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hostler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Hancock, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wallace Pittman</u>				14. MOTHER'S MAIDEN NAME <u>Estella Whisner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-09-9931</u>		17. INFORMANT <u>Mrs. Dora Pittman, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>slight</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While o. m. <u> </u> p. m. <u> </u> 19 <u> </u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumberland, Md.</u>	
20f. (City or town) <u>Cumberland, Md.</u>				20g. (County) <u>Allegany</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>8/17/60</u> , 19 <u> </u> , to <u>11/28/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11/25/60</u> , 19 <u> </u> , and that death occurred at <u>7:15 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>11/30/60</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-1-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSTLER OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 324 Pear Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WILLIAM DEWARREN PORTER				4. DATE OF DEATH Month November Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant Owner				10b. KIND OF BUSINESS OR INDUSTRY Own Business			
11. BIRTHPLACE (State or foreign country) Eckhart, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Josiah Porter				14. MOTHER'S MAIDEN NAME Helen Wonn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 324 Pear Street			
17. INFORMANT Mrs. Annie C. Porter, Cumberland, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> NOVEMBER 15, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR NOV 18 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1914		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		NONE		NONE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		CHILDREN		SIBLINGS	
JAN 15 1869		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		3		2	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER'S SIGNATURE		EXAMINER'S TITLE		EXAMINER'S ADDRESS		EXAMINER'S PHONE	
JAN 15 1914		BALTIMORE, MD.		J. H. HARRIS		M.D.		1234 E. BALTIMORE ST.		BALTIMORE, MD.	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWER'S SIGNATURE		INTERVIEWER'S TITLE		INTERVIEWER'S ADDRESS		INTERVIEWER'S PHONE	
JAN 15 1914		BALTIMORE, MD.		J. H. HARRIS		M.D.		1234 E. BALTIMORE ST.		BALTIMORE, MD.	
DATE OF REPORT		PLACE OF REPORT		REPORTER'S SIGNATURE		REPORTER'S TITLE		REPORTER'S ADDRESS		REPORTER'S PHONE	
JAN 15 1914		BALTIMORE, MD.		J. H. HARRIS		M.D.		1234 E. BALTIMORE ST.		BALTIMORE, MD.	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

12091

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>10 mos. 11 das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Urias</u> Middle <u>J.</u> Last <u>Rowe</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/78</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rubber Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield Frostburg, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-0186</u>	
17. INFORMANT <u>Mr. James R. Rowe</u>		Address <u>Baltimore 24, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycobacterium tuberculosis</u> 422.2 DUE TO <u>Psychotic tendencies</u> Secondary <u>anemia, disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 10, 1960</u> to <u>Nov 21, 1960</u> that I last saw the deceased alive on <u>Nov 21, 1960</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.B. Matthews M.D.</u>		ADDRESS (Street, city or town, state) <u>144 Green St</u> DATE SIGNED <u>11-22-60</u>	
PHYSICIAN'S NAME (Type) <u>L.B. Matthews M.D.</u>		<u>Cumtland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-23-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg Md.</u>		22d. LOCATION (City, town, or county) <u> </u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Montemayor</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12092

CERTIFICATE OF DEATH

12077

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND d. STREET ADDRESS 1 R.F.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GIOVINI Middle SCARINCI Last SCARINCI		4. DATE OF DEATH Month NOVEMBER Day 21 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877 FEB. 17, 1887
9. AGE (In years last birthday) 18283 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Crecchio, Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vincenzo D'Alessandro		14. MOTHER'S MAIDEN NAME Giacinta Scarinci	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Congestive Heart Failure DUE TO (b) Myocardial Degeneration DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/20 to 11/21 , 19 60 , that (I) (we) lost the deceased alive on 11/20 , 19 60 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Lby, Jr.		22b. DATE SIGNED 11/21/60	
22c. PHYSICIAN'S NAME (Type) LEO H. LBY, JR., MD.		22d. ADDRESS 452 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23-60	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. RECEIVED BY REGISTRAR NOV 28 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	

CERTIFICATE OF DEATH

15005

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[Illegible text]

[Illegible text]

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[Illegible text]

[Illegible text]

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[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

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12093
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12078

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 30 RACE STREET	
d. NAME OF HOSPITAL (Type or print) MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle S Last SCATURRO		4. DATE OF DEATH Month NOVEMBER Day 22 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 16, 1911
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.	11. IF UNDER 24 HRS. Months 49 Days 49 Hours 49 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jockey Agent		10b. KIND OF BUSINESS OR INDUSTRY Race Track	
11. BIRTHPLACE (State or foreign country) COLORADO Trinidad		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JERRY SCATURRO		14. MOTHER'S MAIDEN NAME PAULINE DARRO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 129-01-6030	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis & (c) Infarction		INTERVAL BETWEEN ONSET AND DEATH 7 days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1960 to Nov 22, 1960 ; that (I) (we) last saw the deceased alive on Nov 22, 1960 , and that death occurred at 8:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED Nov 22, 1960	
22c. PHYSICIAN'S NAME (Type) CLAY E. DURRETT		22d. ADDRESS 236 W. 1st Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-60	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

13094

CERTIFICATE OF DEATH

13094



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12094

12079

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 36 DAYS	
d. NAME OF HOSPITAL (If not hospital, give place and address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle PETER Last SCHELLHAUS		4. DATE OF DEATH Month NOVEMBER Day 17 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 3, 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Glass Mfrgr.		10b. KIND OF BUSINESS OR INDUSTRY Glass	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATHEW SCHELLHAUS		14. MOTHER'S MAIDEN NAME BARBARA BECKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. 220-16-6141	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 6/10X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Pyelonephritis (c) Benign Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 3 weeks, 3 years 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis, general arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/16 to 11/17 , 19 60 that (I) (we) last saw the deceased alive on 11/16 , 19 60 and that death occurred 8:15 AM from the causes and on the date stated above.			
22a. SIGNATURE S. G. WEISMAN		22b. DATE SIGNED 11/17/60	
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN		22d. ADDRESS 59 Greene St Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/19/60	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR NOV 21 '60	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Haus	

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15075

TESTIMONY OF DEATH

15075

WILLIAM

HARRIS

WILLIAM

CHAMBERLAIN

30 DAYS

CHAMBERLAIN

2 NORTH CHASE STREET

1000 1/2 AMERICAN AVE.

17

NOVEMBER

CHAMBERLAIN

BETWEEN

JOHN

53

NOV. 2, 1935

WHITE

WHITE

1935

CHAMBERLAIN

1000 1/2 AMERICAN AVE.

BARBARA BECKER

1000 1/2 AMERICAN AVE.

CHAMBERLAIN

1000 1/2 AMERICAN AVE.

CHAMBERLAIN

2. O. WILSON

1/11/

1000 1/2 AMERICAN AVE.

1000 1/2 AMERICAN AVE.

12107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle EDWARD Last SCHRIVER		4. DATE OF DEATH Month 11 Day 3 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Borden, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonzo Schriver		14. MOTHER'S MAIDEN NAME Mary Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-4833	
17. INFORMANT Margaret B. Schriver		Address Frostburg, Md. R.D.#2 (Borden)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 550.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute ruptured cecum appendix DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 28 , 19 60 , to Nov 3 , 19 60 , that I last saw the deceased alive on Nov 3 , 19 60 , and that death occurred at 9:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W O McLane M.D.		ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED Nov 4 1960	
PHYSICIAN'S NAME (Type) W O McLane MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/6/60	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR Nov 9 '60	24b. REGISTRAR'S SIGNATURE Arthur J. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12095

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Frederick St.,				d. STREET ADDRESS 11 Frederick St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First MARY Middle E DNA Last SEIFERT		4. DATE OF DEATH Month Nov. Day 10, Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1892	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68		IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min. 68			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Prop.		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Mann's Choice, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Seifert				14. MOTHER'S MAIDEN NAME Laura McVicker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-6865		17. INFORMANT Mr. Mark I. Seifert		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, left colon with 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis to liver and later DUE TO (c) generalized						INTERVAL BETWEEN ONSET AND DEATH 16 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 day , 19 60 to Nov 9 , 19 60 ; that I last saw the deceased alive on 9 Nov , 19 60 , and that death occurred at 2:00A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Carlton Brinsfield		M.D. Carlton Brinsfield M.D.		ADDRESS (Street, city or town, state) 232 Balto. Ave.,		DATE SIGNED 11/11/60	
PHYSICIAN'S NAME (Type) Carlton Brinsfield M.D.		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/60		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 14 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

12101

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1910-01-15</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1960-03-10</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1960-03-15</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12082

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>Gilbert</u> Last <u>SHANHOLTZ</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/04</u>	
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob R. Shanholtz</u>				14. MOTHER'S MAIDEN NAME <u>Nannie V. Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-05-5231</u>		17. INFORMANT <u>Mr. J. Brooke Shanholtz</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157.4</u> DUE TO <u>crisis of liver & ascites</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Co of liver & pancreas</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>month</u> <u>month</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2</u> 19 <u>60</u> to <u>Nov 2</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Nov 2</u> 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. R.M. Schindler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/3/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. R.M. SCHINDLER</u>				22d. ADDRESS <u>43 GREENE STREET</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1890

STATE OF TEXAS

1890

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12097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART--DOA</u>			d. STREET ADDRESS <u>518 FECTIG AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SISK CARL</u>			4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30, 1912</u>		9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline Station</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>CHARLES SISK</u>		
14. MOTHER'S MAIDEN NAME <u>AMANDA DRAKE</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW2</u>		
16. SOCIAL SECURITY NO. <u>214 05 6403</u>			17. INFORMANT <u>BROTHER: KETH SISK</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W.O. Mc Lane</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>NOV 19 1960</u>	
EXAMINER'S NAME (Type) <u>W.O. Mc Lane M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Mem. Gardens</u>	
22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> Cumberland, Md.			
24a. REC'D BY REGISTRAR <u>NOV 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12024

CERTIFICATE OF DEATH

12024

Blank form with faint horizontal lines and a large 'X' mark on the left side.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12098

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12085

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEWIS Middle THORNTON Last SMITH		4. DATE OF DEATH Month NOVEMBER Day 7 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1892
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES SMITH		14. MOTHER'S MAIDEN NAME ? Sarah Jay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 25-20-4736	
17. INFORMANT SON LAWRENCE Smith		Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X DUE TO Pulmonary Congestion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Failure (c) Chronic obstructive Cardiac Vascular Disease - 1 year		INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 Dec 1960 to 7 Nov 1960 , that (I) (we) last saw the deceased alive on 6 Nov 1960 , and that death occurred at 6 PM , from the causes and on the date stated above.			
22a. SIGNATURE David T. Rees		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. DAVID REES.		22d. ADDRESS 601 Montgomerie Ave. Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 10, 1960	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Artemas, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR NOV 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

15082

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20540

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12099

CERTIFICATE OF DEATH

Items 3, 8 Film 275 11-22-60 et

12086

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY MEYERSDALE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian Mae Smith		4. DATE OF DEATH November, 12 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob Lowery D		14. MOTHER'S MAIDEN NAME ??? (D.) CATHARINE DENEEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Smith		Address Meyersdale, PA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 17 1960 to Nov. 12 1960 , that (I) (we) last saw the deceased alive on Nov. 12 1960 and that death occurred at 10:00 P. M., from the causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Wm. James		22d. ADDRESS 413 N. Centre St. Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		23d. LOCATION (City, town, or county) (State) MEYERSDALE PA	
24. FUNERAL DIRECTOR'S SIGNATURE W. C. Price		25a. REC'D BY REGISTRAR NOV 18 '60	
ADDRESS 325 MAIN ST MEYERSDALE, PA		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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CENTRAL OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12087

12100

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>135 Pennsylvania Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Powhatan</u> Middle <u>Jefferson</u> Last <u>Snelling</u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1889</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carmen Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia Fredericksburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Powhatan Snelling</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>War I 705-05-8568</u>		17. INFORMANT <u>Patient's Chart</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Arteriosclerosis, advanced</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (c) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> 19 <u>60</u> , to <u>11/23</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/23</u> 19 <u>60</u> , and that death occurred at <u>1:23</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo N. Ley, Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/24/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. L. Ley</u>		22d. ADDRESS <u>422 N. Centre St.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-26-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md</u>		25a. REGISTRY <u>NOV 26 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u> </u>			

The ashes buried in Arlington National Cem.

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15100

CERTIFICATE OF DEATH

STATE OF NEW YORK

15100

CHIEF CLERK

12101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 WASHINGTON STREET				d. STREET ADDRESS 211 WASHINGTON STREET			
3. NAME OF DECEASED (Type or print) ANNA First DICKEY Middle SPITER Last				4. DATE OF DEATH Nov. 19 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1881	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW SPITER		14. MOTHER'S MAIDEN NAME MARTIN STEWART		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT DR. ALLAN SPITER, BALTIMORE, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 171X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 1960 , to Nov. 18, 1960 , that I last saw the deceased alive on Nov. 18, 1960 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE W R Royce Hodges M.D.				DATE SIGNED 11/21/60			
PHYSICIAN'S NAME (Type) DR. ROYCE W. HODGES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '60	
				24b. REGISTRAR'S SIGNATURE Orlino S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12102

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Greene St.,		d. STREET ADDRESS 112 Greene St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle ELLEN Last STANIFORTH		4. DATE OF DEATH Month November Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clergy		10b. KIND OF BUSINESS OR INDUSTRY Ministry	11. BIRTHPLACE (State or foreign country) Yorkshire, England
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Williams		14. MOTHER'S MAIDEN NAME Elizabeth Nightingale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Sadie E. Triplett		Address Cumberland, Md. 112 Greene St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Artery Disease DUE TO (c) Diarrhea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 hours Diarrhea Dec 51	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-17 , 19 51 , to 11-24 , 19 60 , that I last saw the deceased alive on 11-24 , 19 60 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams M.D.		ADDRESS (Street, city or town, state) 122 So. Centre St.,	
PHYSICIAN'S NAME (Type) W. F. Williams M.D.		DATE SIGNED 11/25/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/27/60	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 28 1960		24b. REGISTRAR'S SIGNATURE Arthur S. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

12102

10-1-1962

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/24/26		5. PLACE OF BIRTH MOBILE, ALABAMA	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. EDUCATION High School Graduate		12. RELIGION Methodist		13. ETHNIC ORIGIN Caucasian		14. SOCIAL SECURITY NUMBER 1-234-567890		15. MOTHER'S MAIDEN NAME JAMES	
16. DATE OF DEATH 4/4/68		17. TIME OF DEATH 10:15 AM		18. PLACE OF DEATH FBI Office, Memphis, TN		19. CAUSE OF DEATH Suicide		20. MANNER OF DEATH Homicide	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF WITNESS JAMES EARL RAY		23. SIGNATURE OF PHYSICIAN JAMES EARL RAY		24. SIGNATURE OF CORONER JAMES EARL RAY		25. SIGNATURE OF JURY JAMES EARL RAY	

OFFICE OF THE ATTORNEY GENERAL
BALTIMORE, MARYLAND

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12109
CERTIFICATE OF DEATH
12090

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Peter Middle Staup Last Staup		4. DATE OF DEATH Month November Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1873
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Staup		14. MOTHER'S MAIDEN NAME Rebecca Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Albert Grindel		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial ischemia DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 48 hours years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 2, 1957 to Nov. 20, 1960 , that (I) (we) last saw the deceased alive on Nov. 20, 1960 , and that death occurred at 3p M, from the causes and on the date stated above.			
22a. SIGNATURE Stanley J. Miles		22b. DATE SIGNED 11.21.60	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONACONING, MARYLAND	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF 11/23/60	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
25a. REC'D BY REGISTRAR NOV 22 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

20151

10

CERTIFICATE OF DEATH

Reg. Dist. No.

12091

12103

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 W. Second Street		d. STREET ADDRESS 20 W. Second Street	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Rachel Stickley		4. DATE OF DEATH Month Day Year Nov. 6. 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. House		14. MOTHER'S MAIDEN NAME Sarah C. Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nellie Randall		Address 20 W. Second St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 4, 1957 to Nov. 6, 1960 , that I last saw the deceased alive on Nov. 4, 1960 , and that death occurred at 10: P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) 236 W. 4th Cumberland Md.	
DATE SIGNED 11/7/60			
PHYSICIAN'S NAME (Type) Clay E. Durrett		236 Virginia Ave. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-60	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12092

12104

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 15 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle N. Last STUMP				4. DATE OF DEATH Month NOVEMBER Day 9 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 16, 1935	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25 Days 25 Hours 25 Min.		IF UNDER 24 HRS. Months 25 Days 25 Hours 25 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Clerk				10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning Station			
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? Grafton USA			
13. FATHER'S NAME WILLIAM CLINGAN (DECEASED)				14. MOTHER'S MAIDEN NAME CLARA Kline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 234-54-4380			
17. INFORMANT PATIENTS CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Diabetes mellitus (c) 12 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene, right foot. Spontaneous abortion of pregnancy 650.0							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-5-1956 to 11-9-1960 , that (I) (we) lost the deceased alive on 11-8-1960 , and that death occurred on 11-9-1960 , from the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin				22b. DATE SIGNED A.M.			
22c. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.				22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 11-9-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-12-60			
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town, or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				25a. REC'D BY REGISTRAR DATE NOV 14 '60			
ADDRESS Cumberland, Md				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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